

Health History Form

Date _____

Name _____ Home Phone (____) _____ Cell (____) _____ Work (____) _____

Address _____ City _____ State _____ Zip Code _____

Occupation _____ Height _____ Weight _____ Date of Birth _____ Sex M F

SS# _____ Emergency Contact _____ Relationship _____ Phone (____) _____

E-mail Address _____ Who referred you to our practice? _____
Name relationship

INSURANCE INFORMATION

INSURED PERSON'S FULL NAME _____ INSURED PERSON D.O.B _____

SOCIAL SECURITY NUMBER _____ RELATIONSHIP TO PATIENT _____ WORK PHONE _____

INSURANCE COMPANY NAME _____ GROUP OR LOCAL NUMBER _____

EMPLOYER NAME _____ FULL ADDRESS OF EMPLOYER _____

DENTAL INFORMATION

YES	NO	UNSURE		YES	NO	UNSURE		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had orthodontic treatment?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold, hot, sweets, or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches, earaches or neck pains?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear removable dental appliances?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain _____					

How would you describe your current dental problem? _____

Date of your last dental exam _____

What was done at that time? _____ Date of last dental x-rays _____

How do you feel about the appearance of your teeth? _____ Do you have any problems with bad breath? _____

MEDICAL INFORMATION

YES NO UNSURE

Are you in good health?

Have there been any changes in your health within the past year? _____

Are you under the care of a physician? If so, what are the conditions being treated? _____

_____ Date of last exam _____

Physician(s)

_____	_____	_____	_____
Name	Phone	Address	City/State/Zip
_____	_____	_____	_____
Name	Phone	Address	City/State/Zip

Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem? _____

Do you wear contact lenses?

Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week? _____ month? _____
If yes, _____ # drinks per day for _____ # of years

Are you alcohol and/or drug dependent? If so have you received treatment? (check one) YES NO

Do you use drugs or other substances for recreational purposes? If yes, please list _____

Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? Very Somewhat Not at all
How many years have or did you use tobacco? _____ How much tobacco did you use per day? _____

